

2016 Hospital Quality Incentive Payment (HQIP) Program

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Overview of the HQIP Program

The Hospital Quality Incentive Payment (HQIP) Program is offered by the State of Colorado under the Colorado Medicaid program. The Colorado Department of Health Care Policy and Financing (HCPF) administers the Colorado Medicaid program. Colorado Medicaid provides health care benefits for qualified Colorado residents. The HQIP Program is one part of the Hospital Provider Fee Program and provides incentive payments to hospitals for improving health care and patient outcomes.

Program Authority

The Colorado Health Care Affordability Act (House Bill 09-1293), Section 25.5-4-402.3, Colorado Revised Statute, authorizes HCPF to assess a hospital provider fee to generate additional federal Medicaid matching funds to expand health care access, improve the quality of care for clients served by public health insurance programs, increase funding for hospital care for Medicaid and uninsured clients, and to reduce cost-shifting to private payers.

The statute further authorizes HCPF to "... pay an additional amount based upon performance to those hospitals that provide services that improve health care outcomes for their patients. This amount shall be determined by the state department based upon nationally recognized performance measures established in rules adopted by the state board. The state quality standards shall be consistent with federal quality standards published by an organization with expertise in health care quality, including but not limited to, the Centers for Medicare and Medicaid Services, the agency for healthcare research and quality, or the national quality forum."

A 13-member Hospital Provider Fee Oversight and Advisory Board (Advisory Board), including five hospital members; one statewide hospital organization member; one health insurance organization or carrier member; one health care industry member; two consumers; one health insurance member; and two HCPF members, provide oversight of the Hospital Provider Fee Program. This Advisory Board is responsible for working with HCPF and the Medical Services Board to develop the hospital provider fee model, monitor the implementation of the bill, help with preparation of annual reports on this program, and ensure that the Medicaid and Child Health Plan *Plus* (CHP+) eligibility expansions are implemented as intended.

The Advisory Board appointed a subcommittee comprised of staff from hospitals, the Colorado Hospital Association and the Department to provide recommendations on the quality portion of the statute. The major tasks of the subcommittee include:

1. Recommend performance measures that form the basis of the incentive payment.
2. Recommend how payments should be made.
3. Communicate with hospitals.
4. Gather and analyze data required for the performance measures.

The subcommittee recommends performance measures and scoring to the Advisory Board. HCPF calculates the incentive payments based on measures and scoring approved by the Advisory Board. Once approved, the HCPF Medical Services Board and the Centers for Medicare and Medicaid Services (CMS) must then approve the payments. Incentive payments are made once all approvals have been obtained. Hospital participation in the HQIP program is voluntary.

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2015 HQIP Subcommittee Members

Lisa Camplese, Vice President of Clinical Quality/Care Coordinator, Centura Health

Kelley Degarate, Director of Patient Safety and Performance Excellence, Longmont United Hospital

Lindy Garvin, Vice President of Quality Improvement and Patient Safety, HealthONE

Daniel Hyman, MD, Chief Quality and Patient Safety Officer, Children's Hospital, Colorado

Thomas MacKenzie, MD, Chief Medical Officer and Chief Quality Officer, Denver Health

Holly Saratella, Data Integrity Quality Specialist, University of Colorado Health

David Solawetz, Director of Quality, Process Improvement and Clinical Informatics, Middle Park Medical Center

Kristin Stocker, Regulatory Affairs and Patient Relations Manager, University of Colorado Health

Nancy Griffith, Colorado Hospital Association

Diane Rossi MacKay, Colorado Hospital Association

Ryan Westrom, Colorado Hospital Association

Katie Brookler, Colorado Department of Health Care Policy and Financing

Lila Cummings, Colorado Department of Health Care Policy and Financing

Diana Lambe, Colorado Department of Health Care Policy and Financing

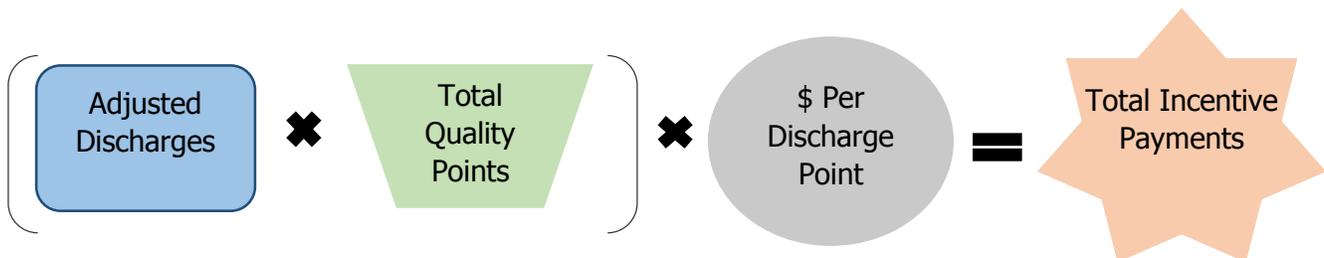
Ana Lucaci, Colorado Department of Health Care Policy and Financing

Incentive Payment Calculation

The HQIP incentive payments are based on each hospital's performance on measures selected annually by a subcommittee of the Hospital Provider Fee Oversight and Advisory Board. Staff from hospitals, HCPF and the Colorado Hospital Association are members of the subcommittee. Data to assess performance is obtained from a variety of sources: hospitals report to HCPF on selected measures and data is obtained from Medicaid claims data, Hospital Compare, etc. for other measures.

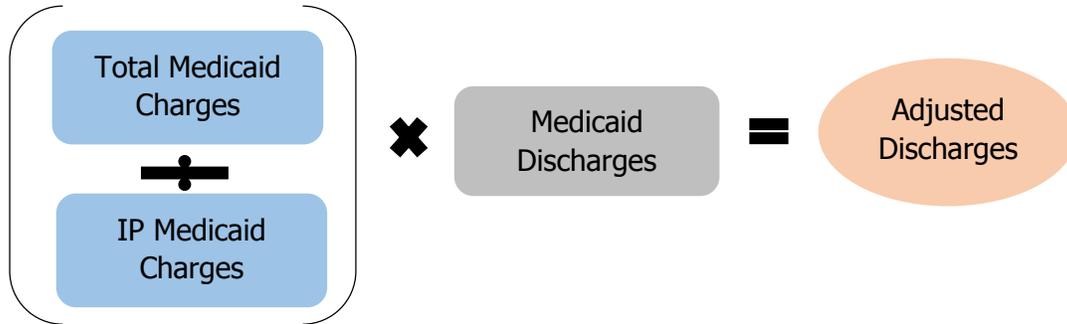
The total amount of funds available for incentive payments for 2016/17 is approximately \$84 million. The incentive payment calculation is displayed below.

Annual adjusted discharges are multiplied by the total quality points earned by a hospital. The product of this equation is then multiplied by the dollars per discharge point earned by the hospital to arrive at the total incentive payment.



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Adjusted discharges are calculated by dividing the total Medicaid charges by inpatient Medicaid charges. This quotient is multiplied by total inpatient Medicaid discharges to arrive at Adjusted Discharges. This calculation is done to account for hospitals whose total Medicaid outpatient charges may be less than total Medicaid inpatient charges.



Dollars per Discharge Point

A hospital's performance level determines the quality points earned. The \$ per Discharge Point (above) is dependent on the total quality points earned by a hospital. The higher the total quality points, the more money each discharge point is worth.

There are five tiers delineating the dollar value of a discharge point. Each ascending tier has a higher dollar per discharge point. The tiers are assigned at ten quality point increments. The Dollar per Discharge Point for Tier 2 is 1.5x greater than Tier 1, Tier 3 is 2x greater than Tier 1, Tier 4 is 2.5x greater than Tier 1, and Tier 5 is 3x greater than Tier 1. Tier 1 is determined by the available annual funding and the statewide distribution of the quality points. As an example, for 2015, the tiers were as follows:

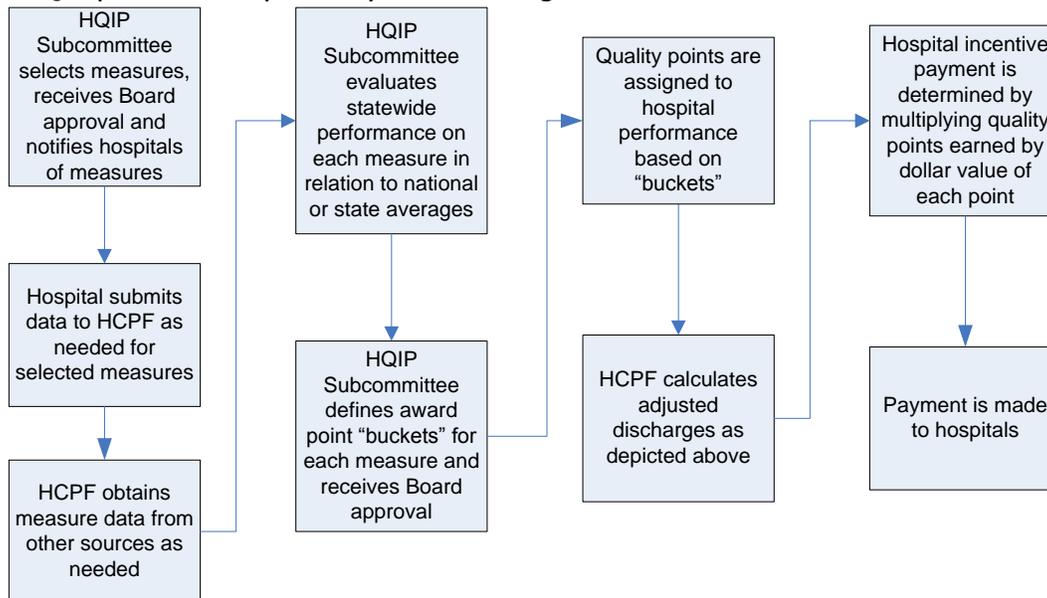
Example: 2015 Payment Tiers based on Total Quality Points Earned

Tier	Total Quality Points	Dollar per Discharge Point
1	1-10	\$7.92
2	11-20	\$11.88
3	21-30	\$15.84
4	31-40	\$19.80
5	41-50	\$23.76

The above table shows that if a hospital earned 23 total quality points, the hospital would be paid \$15.84 per discharge point. If a hospital earned 46 total quality points, the hospital would be paid \$23.76 per discharge point.

Annual HQIP Process

The annual HQIP process is depicted by the following flowchart.



Measure Information

Participation in the HQIP program is voluntary. Hospitals can report data and information on up to five (5) measures annually. Reporting on five measures affords the opportunity to earn all available quality points.

The HQIP program uses three categories of measures:

Base Measures are the basic set of measures for hospital use. Hospitals participating in HQIP are required to report on these measures, as applicable. Quality points are awarded for each measure reported, based on the hospital's performance on each measure.

Optional Measures are measures that can be substituted on a one-for-one basis, if a hospital cannot use one or more of the Base Measures. For example, a hospital that does not have an emergency room can substitute the *Participation in RCCO* measure from the Optional Measure list instead of the Base Measure *Emergency Department Process*. Quality points are awarded for each measure reported, based on the hospital's performance on each measure.

Maintenance Measures are measures that are important to quality of care and patient safety but have little room for improvement over current statewide performance levels. The HQIP subcommittee will continue to review the statewide rates to be sure that gains are maintained. No points are assigned for Maintenance measures.

Hospitals must report all of the Base Measures if they apply to the hospital's services. If any Base Measure does not apply (e.g., cesarean section rate would only apply to hospitals offering routine obstetric care), an Optional Measure may be substituted for the Base Measure that does not apply. Optional Measures must be used in the order listed (e.g., *Active Participation in RCCO* must be used before any other Optional Measures are used).

A Note on 30-Day All-Cause Readmissions and HCAHPS

Please note that data for the *30-Day All-Cause Readmission* or *HCAHPS* Base Measures are not available until mid-July. Some hospitals who reported on the *30-Day All-Cause Readmission* or *HCAHPS* Base Measures in 2015 ended up being ineligible for the measure due to too few Medicaid discharges or lack of public HCAHPS data on Hospital Compare. For HQIP 2016, HCPF will not normalize scores as a result of a hospital reporting on *30-Day All-Cause Readmission* or *HCAHPS* Base Measures but not being eligible to do so.

If you are at risk for not being eligible for either the *30-Day All-Cause Readmission* or *HCAHPS* Base Measures, we encourage you to submit data for the next available Optional Measure (i.e., Optional Measure 1: RCCO Engagement; or Optional Measure 2: Advanced Care Planning, if you are already using Optional Measure 1; or Optional Measure 3: Smoking Screening and Follow-Up, if you are already using Optional Measures 1 and 2).

If you end up being eligible for *30-Day All-Cause Readmission* or *HCAHPS* Base Measures, the additional Optional Measure will not be scored. If you end up not being eligible for *30-Day All-Cause Readmission* or *HCAHPS* Base Measures, you will be scored on the Optional Measure. If you choose not to submit data for an additional Optional Measure and end up not being eligible for *30-Day All-Cause Readmission* or *HCAHPS* Base Measures, you will be scored only on the remaining measures for which you were eligible.

2016 Measures

(Measures in red are prospective—focusing on activities in 2016. All other measures are retrospective—focusing on activities in 2015, as indicated below.)

Measures for the year beginning January 1, 2016 are listed below. Each measure is worth up to 10 points. Hospitals must report on the five Base Measures, as applicable. If any Base Measure does not apply to a hospital’s services (e.g., routine deliveries are not performed, so the Cesarean Section measure does not apply), Optional Measures, in the order listed, can be substituted for a Base Measure on a one-to-one basis.

The maximum score a hospital can receive is 50 points, 10 points for each measure.

Detailed information about each measure, criteria required to meet each measure, and information about what will need to be reported for each measure begins on page 8.

2016 Base Measures	Measure Steward	Data Source	Effective Service Dates
1. Emergency Department Process	HQIP Subcommittee	Hospital	January 1, 2016 – December 31, 2016
2. Cesarean Section	Joint Commission: PC-02a	Hospital	January 1, 2015 – December 31, 2015

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2016 Base Measures	Measure Steward	Data Source	Effective Service Dates
3. 30-Day All-Cause Readmissions	CMS	MMIS Claims Data	January 1, 2015 – December 31, 2015
4. HCAHPS - Percentage of patients who gave their hospital a rating of "9" or "10" on a scale of 0 (lowest) to 10 (highest).	HCAHPS	Hospital Compare	Rates shown on Hospital Compare as of July 2016
5. Culture of Safety	HQIP Subcommittee	Hospital	January 1, 2015 – April, 2016

2016 Optional Measures	Measure Steward	Data Source	Effective Service Dates
1. Active Participation in RCCOs	HQIP Subcommittee	Hospital	January 1, 2016 – December 31, 2016
2. Advance Care Planning (Advance Directives)	NQF: Measure ID 0326	Hospital	January 1, 2015 – December 31, 2015
3. Tobacco Screening and Follow-up	Joint Commission: TOB-1, TOB-03	Hospital	January 1, 2015 – December 31, 2015

2016 Maintenance Measures	Measure Steward	Data Source	Effective Service Dates
1. PE/DVT	AHRQ	CHA Hospital Report Card	January 1, 2015 – December 31, 2015
2. CLABSI	CDC	CDPHE	August 1, 2015 – July 31, 2015
3. Early Elective Deliveries	Joint Commission PC-01	CMS	January 1, 2015 – December 31, 2015

Changes from last year

- The Culture of Safety measure was moved from an Optional Measure to a Base Measure.
- The Early Elective Deliveries measure was moved from a Base Measure to a Maintenance Measure.

What You Need to Know

All hospitals wishing to participate in the HQIP program can report on up to five (5) measures for 2016. Participating hospitals are required to report on the Base Measures as long as they apply to the services routinely provided by the hospital. If any of the five Base Measures do not apply, the Optional Measures can be substituted for a Base Measure on a one-for-one basis in the order in which the Optional Measures are listed. Hospitals cannot report on an Optional Measure if a Base Measure applies.

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Example 1: Hospital X does not have an emergency room; therefore, the *Emergency Department Process* Base Measure does not apply to Hospital X. Hospital X must therefore choose Optional Measure 1, *Active Participation in RCCOs* to report.

Example 2: Routine deliveries are not performed at Hospital Y; therefore, Hospital Y must report on Optional Measure 1, *Active Participation in RCCOs* in place of the *Cesarean Section* Base Measure.

Example 3: Hospital Z does not perform routine deliveries and does not participate in the HCAHPS program; therefore, Hospital Z cannot report on the *Cesarean Section* Base Measure and has no HCAHPS data to report. Hospital Z would report on Optional Measures 1 and 2, *Active Participation in RCCOs* and *Advance Care Planning (Advance Directives)*.

Base Measures

Base #1 Emergency Department Process Measure (2 points for each initiative, up to 10 points)

The following interventions will be effective during the period January 1, 2016 through December 31, 2016.

1. All discharged ED patients are given information about local primary care clinics if they have no PCP.
2. All discharged ED patients are provided information about available nurse advice lines.
3. Hospital notifies RCCO of the ED visit within 24 hours of visit.
4. ER policies or guidelines that state providers will not provide replacement prescriptions for opioids that are lost, destroyed or stolen are in effect by March 1, 2016.
5. ER policies or guidelines are in place indicating no long acting opioids are prescribed in the ER are in effect by March 1, 2016).

Data submission is not required for this measure. Hospitals will be asked to attest to the initiatives they will implement and may be asked to produce evidence of their compliance at some point during the 2016 calendar year.

Base #2 Cesarean Section (up to 10 points)

This measure uses the JCAHO calculation and sampling for PC-02 in the perinatal care measure set, described in the following link: <https://manual.jointcommission.org/releases/TJC2014A1/>. This measure counts the number of cesarean sections performed during 2015 on all patients (not just patients with Medicaid coverage). Hospitals will be required to submit data from calendar year 2015 for this measure in late spring of 2016.

Base #3 30-Day All-Cause Readmission (up to 10 points)

The readmission calculation is defined by the Centers for Medicare and Medicaid Services (CMS) and counts Medicaid clients with readmissions during 2015. Hospitals do not need to submit data for this measure; it will be calculated by HCPF for calendar year 2015. Patients must be enrolled in Medicaid for at least 365 days prior to a discharge date to be included in this measure; therefore, the numerators, denominators and subsequent readmission rates will be lower than a hospital calculates with its own data.

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**Please refer to section "A note on *30-Day All-Cause Readmissions and HCAHPS*" for important information about this measure.

[Specifications for this Readmissions measure.](#)

Base #4 HCAHPS (up to 10 points)

This measure is the question on the HCAHPS survey showing the percentage of patients who gave the hospital a rating of a "9" or "10" on a scale from 0 (lowest) to 10 (highest). Data from this measure will be taken from the most current data on [Hospital Compare](#) to provide a patient-mix adjustment to the data.

**Please refer to section "A note on *30-Day All-Cause Readmissions and HCAHPS*" for important information about this measure.

Base #5 Culture of Safety Measure (up to 10 points)

This measure is designed to promote a culture of safety in hospitals. Hospitals can choose to implement/report on any three of the following four activities for up to 10 points:

- #1: Patient and Family Advisory Council
- #2: Hospital Safety Leadership
- #3: Patient [Safety Survey](#) (*choose either 3A or 3B*)
- #4: [Unit Safety Huddles/Briefings](#)

Definitions, criteria and reporting requirements for each of these activities is provided below.

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Patient and Family Advisory Council

Measure Definition: An established council with members who are former patients or family members of former patients.

Measure Criteria:

- The council must meet at least four times per year.
- At least three council members must be former patients or family members of former patients.
- The purpose of the council should be to provide advice and guidance regarding patient safety and/or patient experience issues identified by council members.
- There should be demonstration by the organization that such advice and guidance was taken into consideration in the planning and improvement of patient care experience and outcomes.

Hospital Safety Leadership

Measure Definition: One of the following is conducted on a regular basis:

- Weekly leadership safety rounds, defined as planned visits to the appropriate hospital departments by hospital executive(s) or senior leaders for the purpose of demonstrating leadership's commitment to a strong patient safety program, and identifying and responding to patient safety concerns identified by hospital staff. A senior leader is defined as someone at a Division Director level or higher.

OR

- Daily leadership safety huddles/briefings, defined as short daily meetings attended by a hospital executive or senior leader in which representatives from all departments gather to report on potential clinical safety concerns for the day. A senior leader is defined as someone at a Division Director level or higher.

Measure Criteria:

- Leadership safety rounds should be attended weekly by a hospital executive or senior leader. Hospital executives or senior leaders will round on at least 50% of the hospital departments during a year.
- Daily leadership safety huddles/briefings are conducted with the appropriate personnel seven days per week. A hospital executive or senior leader (or designee on weekends) will attend the meeting. A senior leader is defined as someone at a Division Director level or higher.

Patient Safety Survey

Measure Definition: Completion of a survey that gathers data regarding hospital staff's perceptions of the organization's safety culture and demonstration of actions taken by the hospital to address issues identified by survey responses.

Measure Criteria:

- Survey must include at least ten questions related to a safety culture and can be combined with another survey of hospital staff.
- Safety culture questions must be from a survey tool that has been tested for validity and reliability.
- Survey questions can be part of another survey tool as long as it meets the above criteria.
- Safety culture survey has been administered within the past 24 months.
- Actions taken in response to the survey should address those survey questions that demonstrated poorest scores on the survey.

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Unit/Department Safety Huddles/Briefings

Measure Definition: Short meetings held in nursing units and in clinical departments to identify possible patient safety issues or concerns.

Measure Criteria:

- Meetings should be held daily
- Meetings should be led by unit or department leader or designee
- All available department/unit staff should be present

Hospitals choosing the *Culture of Safety* measure will be required to provide documentation described below. Documentation will be due to HCPF in May/June 2016. Documentation should give a high-level picture of the *Culture of Safety* initiative/s for the time period January 2015 through April 2016. We are interested in what is being done and the results/effect on patient care. The documentation should not exceed two pages.

#1: Patient and Family Advisory Council—a summary (1-2 paragraphs) that includes the following elements: the number of meetings held from January 2015 to December 2015 (if PFAC is already established), one or two of the major discussion topics and any actions planned or implemented as a result of the discussion, or the number of planning meetings between January 2016 – April 2016 (if PFAC is not yet established).

#2: Hospital safety leadership --a short summary (1-2 paragraphs) of some of the issues identified and addressed during these meetings/discussions.

#3: Patient Safety Survey--a short summary (1-2 paragraphs) of survey findings, what has been done in 2015 or is being planned for 2016 as a result of the survey and the number of staff completing the survey.

#4 Unit Safety Huddles/Briefings--a short summary (1-2 paragraphs) of some of the issues identified and the number and description of the units on which briefings are conducted.

Optional Measures (OM)

OM #1: Active Participation in RCCOs (up to 10 points)

Hospitals must meet two criteria (#1 and one of the options under #2a – 2e listed below) to demonstrate Active Participation:

1. Notification to RCCO of Inpatient Hospitalization admission (RCCO name and contact information is on Medicaid's eligibility verification notice)

AND one of the means of active participation from the list below:

- 2a. Joint efforts to improve population health
- 2b. Care coordination collaboration (e.g., sharing of care transition plan)
- 2c. Case management collaboration (e.g., conversations between case managers, RCCO case manager invited to case conferences, etc.)
- 2d. Collaboration on high utilizers to decrease ER visits and IP admissions
- 2e. Participation in RCCO level advisory committee meetings or similar meetings.

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Hospitals will be required to inform HCPF of the criteria they intend to undertake throughout 2016. A random check of participation will be assessed by the RCCO.

OM #2: Advance Care Planning (Advance Directives) (up to 10 points)

The *Advance Care Planning* measure is based on the definition provided by the National Quality Forum (NQF) for the number of patients 65 years of age or older who have an advanced care plan documented or who did not wish to provide an advance care plan. Measure specifics can be found on the [NQF website](#) (measure ID: 0326).

Hospitals will be required to submit data from calendar year 2015 to HCPF in late spring of 2016. Random sampling is allowed (see sampling guidelines below).

OM #3: Tobacco Screening and Follow-Up (up to 10 points)

The *Tobacco Screening and Follow-Up* measure is based on the Joint Commission definitions for the number of patients 18 years of age or older who were screened for tobacco use and, if positive, referred to or refused evidence based outpatient counseling AND received or refused a prescription for FDA-approved cessation medication at discharge ([TOB-01 and TOB-03](#), Screening for Tobacco Use and Tobacco Use Treatment Provided or Offered). The measures are also National Quality Forum (NQF) endorsed and details can be found on the [NQF website](#) (measure IDs #1651 and 1656).

Hospitals will be required to submit data from calendar year 2015 to HCPF in late spring of 2016. Random sampling is allowed (see sampling guidelines below).

Maintenance Measures (MM)

MM #1: PE/DVT (no points)

Hospitals do not need to submit data for this measure. The data source for this measure is the [Colorado Hospital Report Card](#).

MM #2: CLABSI (no points)

Hospitals do not need to submit data for this measure. The data source for this measure is the NHSN data submitted to the Colorado Department of Public Health and Environment.

MM #3 Early Elective Deliveries (no points)

This measure uses the JCAHO calculation and sampling for PC-01 in the perinatal care measure set, described in the following link: <https://manual.jointcommission.org/releases/TJC2014A1/>.

Measure Resources

Advance Care Planning

<http://www.ahrq.gov/research/findings/factsheets/aging/endliferia/index.html>

Colorado MOST form: <http://www.polst.org/wp-content/uploads/2012/11/CO-MOST-Form.pdf>

Care Transitions

<http://healthy-transitions-colorado.org/>

Culture of Safety

General resource: http://www.jointcommission.org/topics/patient_safety.aspx

Patient and Family Advisory Council http://www.ipfcc.org/advance/Advisory_Councils.pdf

Patient and Family Advisory Council Toolkits:

http://c.ymcdn.com/sites/www.theberylinsitute.org/resource/resmgr/webinar_pdf/pfac_toolkit_shared_version.pdf

<http://www.patient-experience.org/Resources/Best-Practices/Case-Studies/Patient-Advisory-Council-Toolkit.aspx>

<http://www.nichq.org/sitecore/content/medical-home/medical-home/resources/pfac-toolkit>

Hospital Safety Leadership:

<http://www.ihl.org/resources/Pages/Changes/DevelopaCultureofSafety.aspx>

HQIP/CMS 30-day All-Cause Readmissions Specifications:

<https://www.colorado.gov/pacific/sites/default/files/2016%20March%20HQIP%2030-day%20all-cause%20readmission%20measure.pdf>

Safety Huddle (video): <http://www.hret.org/resources/5750004127>

Safety Huddle: <http://www.psqh.com/septemberoctober-2011/980-daily-check-in-for-safety-from-best-practice-to-common-practice.html>

Patient Safety Survey from AHRQ <http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/hospital/index.html>

The Colorado Hospital Association provides access to the Patient Safety Survey via an online tool for hospital use. Survey results are calculated and provided to the hospital for analysis and planning.

Standup Daily Unit Safety Briefings:

<http://www.ihl.org/resources/Pages/Changes/ConductSafetyBriefings.aspx>

Standup Daily Unit Safety Briefings:

<http://www.ihl.org/resources/Pages/Tools/SafetyBriefings.aspx>

Sampling

Hospitals that use JCAHO sampling for a measure can report the data as sampled for JCAHO. Hospitals that are not JCAHO accredited may sample using the sample size requirements below.

Sample Size Requirements

Hospitals can use sampling to report HQIP measures. The size of the sample depends on the number of cases that qualify for a measure. Hospitals need to use the next highest whole number when determining their required sample size. The sample must be a random sample (i.e. every third record, every fifth record, etc.), taken from the entire 12 months of the year and cannot exclude cases based on physician, other provider type or unit.

Hospitals selecting sample cases must include at least the minimum required sample size. The sample size table below shows the number of cases needed to obtain the required sample size. A hospital may choose to use a larger sample size than is required.

Hospitals selecting sample cases for a measure must ensure that the annual patient population and annual sample size for each measure sampled meet the following conditions:

Annual Sample Size

Annual number of patients meeting measure denominator	Minimum Required Sample Size "n"
>1500	322
101-1500	20% of discharges in denominator, but minimum of 30 discharges reviewed
30 -100	100%
0 - 29	Sample size is too small. Hospital is not eligible for this measure.

Examples

- A hospital's number of elective deliveries is 77 patients for the year. Using the above table, no sampling is allowed – 100% of the cases should be reviewed.
- A hospital's number of deliveries is 401 patients for the year. Using the above table, the required sample size is 80 cases ($401 \times .20 = 80$) for the year.

Measure History

The following table shows how the HQIP measures have changed since the program's inception. One goal of the HQIP program is to provide incentives to hospitals on aspects of care important to Medicaid clients. Measures used for incentive payments can change over time for various reasons, some of which include:

- Statewide performance has improved to the extent that there is little room for improvement.
- To encourage more hospitals to participate in the program. For example, hospitals that do not offer obstetric services would not be eligible to report on two of the measures in 2015. For this reason, Optional Measures were introduced for 2015 to be used for hospitals not eligible to report some measures.
- The needs of Medicaid clients change over time.
- Research has shown the measure has little or no impact on improving patient health, improving the patient experience or lowering the overall cost of care.

B=Base Measure M=Maintenance Measure O=Optional Measure

Measure	2012	2013	2014	2015	2016
Central-line Associated Blood Stream Infection (CLABSI)	X	X	B	M	M
Postoperative Pulmonary Embolism/Deep Vein Thrombosis (PE/DVT)	X	X	M	M	M
Early Elective Deliveries	X	X	B	B	M
Discharge Instruction Process	X				
30-Day All-Cause Readmissions*		X	B	B	B
Cesarean Sections		X	B	B	B
Emergency Department Process*			B	B	B
Patient Satisfaction (HCAHPS)				B	B
Culture of Safety				O	B
Active Participation in RCCOs				O	O
Advance Care Planning				O	O
Tobacco Screening and Follow-Up*				O	O

*includes Medicaid patients only

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The following table shows statewide performance on measures since the inception of the HQIP program:

Measure Name	2012	2013	2014	2015
Central line associated blood stream infection (CLABSI)*	1%	1%	.8%	--
Post-operative Pulmonary Embolism/Deep Vein Thrombosis (PE/DVT)*	441/100,000 Patients*	552/100,000 Patients*	478/100,000 Patients*	--
Early Elective Deliveries**	6.81%	1.52%	2.24%	2.39%
Cesarean Section**	N/A	24.69%	22.05%	21.38%
ED process measure				
Local PCP contacts given if no PCP			90%	76%
Nurse advice line info given			70%	96%
RCCO notified of ER visit			61%	74%
No replacement opioid prescriptions			----	89%
No long acting opioids prescribed			----	83%
30-Day All-cause Readmissions-MMDN methodology***	N/A	9.07%	9.49%	--
30-Day All-cause Readmissions - CMS methodology	--	--	--	13.07%
HCAHPS-Percentage of hospitals scoring "9" or "10" out of a possible 0 (lowest) and 10 (highest)				74%

*as reported through NSHN or CHA Report Card

**as reported to HCPF by each hospital

***includes Medicaid patients only. Calculated by HCPF based on paid claims.

The statewide CLABSI rate has dropped .2% over three years. The PE/DVT rate had a slight increase for 2014 but dropped again in 2015. Early Elective Deliveries dropped dramatically from the 2013 rate and continues to stay low.

Nearly all hospitals are providing persons who have an emergency room visit information on available nurse advice lines. There was a decrease in the number of hospitals that provided local PCP contact information to persons without a PCP. Close to $\frac{3}{4}$ of the hospitals are reporting ER visits to RCCOs and there is high participation in efforts to reduce opioid prescribing in the ER.

The 30-day hospital readmission rate calculation changed in 2015 in order to align with the CMS 30-day hospital readmissions calculation. This rate cannot be compared to previous year's rates because of this change.

Nearly 75% of patients discharged from Colorado hospitals would rate their hospital a 9 or 10 on a scale of 1 (lowest) to 10 (highest).

FAQs

Who can I contact if I have questions not answered here?

Please contact Heidi Walling at Heidi.Walling@state.co.us.

What is the hospital provider fee?

Please follow this link for information about the hospital provider fee:

<https://www.colorado.gov/pacific/hcpf/hospital-provider-fee>

What happens if our hospital does not participate in this program? Are we allowed to participate the following year?

Yes! It is acceptable not to participate one year and to participate the next year. Failure to send data or certify initiatives means the hospital will not be eligible to be paid for that participation but may participate again the following year.

Do specialty hospitals (psychiatric hospitals, Long Term Acute Care Hospitals, Rehabilitation Hospitals, etc.) have an opportunity to participate in the program?

The legislation specifies that psychiatric hospitals are excluded from participation. All other hospitals are eligible to participate.

Does a hospital have an opportunity to preview all data and submit comments to HCPF prior to finalization of the incentive payment?

Hospitals have the opportunity to check the accuracy of the data submitted to HCPF, if any, during an appeal period shortly after the initial data submission. This appeal period usually occurs two to three weeks after the deadline for submitted data.

How is data submitted?

In the past data has been submitted via an online data collection form similar to Survey Monkey, accessed via the web. We always strive to improve data submission, so this form may not be the method used in the future.

How much money is paid to hospitals from the HQIP program?

The amount of money available for quality incentives is a percentage of hospital payments made in the previous year. Beginning in 2015 and going forward it is 7% of the Medicaid fee-for-service payments made for inpatient and outpatient hospital services in the previous state fiscal year (i.e., the 2016 payment is 7% of the payments made to hospitals for services in state fiscal year 2014-15).

How much money can one hospital receive from the HQIP program?

The amount of money a hospital can receive is dependent upon several factors: the total funds available, the hospital's performance on the measures, the number of inpatient discharges paid for by Medicaid and the number of outpatient visits paid for by Medicaid. Beginning in 2015 the closer a hospital's total quality points is to 50, the more each point is worth. The approximate amount of funds available for payment in 2016 is \$84 million.

How are the incentive payments made?

The incentive payment is one part of the monthly hospital provider fee payment made to hospitals.

How much can a Critical Access Hospital earn?

For 2014, CAH incentive payments were between \$20,000 and \$38,000. Payments are based on Medicaid volume and performance on quality measures.

What measures require hospitals to submit data or information?

For 2016 hospitals will need to submit data for the *Cesarean Section* measure and narrative information on the *Culture of Safety* measure. If Optional Measures are used, data submissions are required for the *Advance Care Planning (Advance Directives)* and *Tobacco Screening and Follow-Up* measures.

If I make a mistake in reporting data can I correct it?

There is a window of time in which hospitals can verify and correct data submitted. After that time, no changes are allowed to the submitted data.

Who can sign the data collection form?

Anyone who is authorized to sign for the organization can sign the data collection form. Signing the form means the person signs guarantees to the Department that the information provided is accurate.

What does the attestation statement mean?

The attestation means that the person signing guarantees to the Department that the information provided on the data collection form is accurate.